

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/13/2011	
NAME OF PROVIDER OR SUPPLIER  SYCAMORE SPRINGS REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN47353			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 04/13/11</p> <p>Facility Number: 000510 Provider Number: 155507 AIM Number: 100285440</p> <p>Surveyor: Mark Bugni, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Sycamore Springs Rehabilitation Centre was found in substantial compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. The facility has a capacity of 50 and had a</p>			K0000	<p>Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies.</p> <p>This plan of correction is prepared and submitted because of requirement under state and federal law.</p> <p>Please accept this plan of correction as our credible allegation of compliance.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/13/2011	
NAME OF PROVIDER OR SUPPLIER  SYCAMORE SPRINGS REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN47353			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0046  SS=C	<p>census of 31 at the time of this visit.</p> <p>Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 04/15/11.</p> <p>The facility was found in substantial compliance with the aforementioned regulatory requirements as evidenced by the following</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure 1 of 1 battery backup lights was tested monthly for thirty seconds over the past year, or had a ninety minute annual test, to ensure the light would provide lighting during periods of power outages to protect 31 of 31 residents. Section 7.9.3 requires a functional test shall be conducted on every required emergency lighting system at 30 day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 1/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the</p>			K0046	<p><b><i>K046 Requires emergency lighting of at least 1 ½ hour duration is provided in accordance with 7.9 19.2.9.1</i></b></p> <p>The facility will ensure this requirement is met through the following measures:</p> <ol style="list-style-type: none"> <li>No facility occupants were harmed.</li> <li>All facility occupants are at risk.</li> <li>The emergency generator room battery backup light was replaced with a new light. It was then successfully tested for 30 seconds on 4/21/11 and for 1 ½ hours on 4/22/11</li> <li>The Maintenance Director or designee will test the emergency generator room battery back up light at least 30 seconds every 30 days and 1 ½ hours annually (Attachment A). All findings will be included in the</li> </ol>		04/22/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/13/2011	
NAME OF PROVIDER OR SUPPLIER  SYCAMORE SPRINGS REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN47353			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0052	<p>owner for inspection by the authority having jurisdiction. This deficient practice could affect all residents.</p> <p>Findings include:</p> <p>Based on observation on 04/13/11 at 12:15 p.m. with the maintenance supervisor, the emergency generator room had one battery backup light mounted on the wall. Based on an interview with the maintenance supervisor on 04/13/11 at 12:30 p.m., the battery powered backup light is not tested monthly for thirty seconds, or tested annually for a ninety minute duration.</p> <p>3.1-19(b)</p>				<p>facility's Quality Improvement program and the plan of action adjusted accordingly.</p> <p>5. The above corrective measures were completed on or before 4/22/11</p>		
SS=C	<p>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4</p> <p>Based on record review and interview, the facility failed to ensure 4 of 12 fire drills conducted over the past year included the transmission of a fire alarm signal to protect 31 of 31 residents. NFPA 72, National Fire Alarm Code, in Table 7-3.2, Testing Frequencies at number 23 requires monthly testing of the Supervisory Station</p>			K0052	<p><b>K052</b> Requires a fire alarm system is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The systems has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72.</p>		04/22/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155507		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/13/2011	
NAME OF PROVIDER OR SUPPLIER  SYCAMORE SPRINGS REHABILITATION CENTRE				STREET ADDRESS, CITY, STATE, ZIP CODE 215 W HIGH ST LIBERTY, IN47353			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Fire Alarm Systems receivers. This deficient practice could affect all residents in the facility.</p> <p>Findings include:</p> <p>Based on a review of the Monthly Fire Drill reports with the maintenance supervisor on 04/13/11 at 10:00 a.m., the fire drills conducted on 04/06/10 at 5:00 a.m., 07/14/10 at 2:30 a.m., 10/08/10 at 3:05 a.m. and 01/20/11 at 2:00 a.m. did not indicate the fire alarm system was activated during the fire drills and the fire alarm activation box on the reports was not checked. Based on an interview with the maintenance supervisor on 04/13/11 at 10:30 a.m., third shift fire drills are silent drills and the fire alarm system is not activated. The fire alarm system is not tested during day time work hours after third shift fire drills.</p> <p>3.1-19(b)</p>				<p>9.6.1.4</p> <p>The facility will ensure this requirement is met through the following measures:</p> <ol style="list-style-type: none"> <li>1. No occupants were harmed.</li> <li>2. All occupants are at risk.</li> <li>3. The fire alarm system was successfully tested on including the transmission of a fire alarm signal.</li> <li>4. The Maintenance Director or designee will conduct quarterly fire drills on each shift per the facility preventative maintenance program (Attachment B). Fire drills conducted on third shift will test the fire alarm signal during day time work hours after the third shift fire drill. All findings will be included in the facility's Quality Improvement program and the plan of action adjusted accordingly.</li> <li>5. The above corrective measures will be completed on or before 4/22/11.</li> </ol>		